Labour Law and Welfare Systems in an Era of Demographic, Technological, and Environmental Changes

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Author
Michele Tiraboschi, University of Modena and Reggio Emilia (*Italy*)

English Language Editor
Pietro Manzella, ADAPT (*Italy*)

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By

Michele Tiraboschi

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By Michele Tiraboschi

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PREFACE

What we are witnessing today is a significant transformation of work and the economy. The expression 'great transformation' is not coincidental, as it makes explicit reference to Karl Polanyi's book, which examined the rise of the modern market economy. Like the transformation illustrated by Polanyi, current social changes are difficult to define. Due to globalisation which, thanks to the Internet of Things (IoT) and Big Data, has made it possible to connect physical devices and govern fully-digitalised supply chains. Production processes and companies undergo change, and so does work. Concurrently, society is evolving as workers' and consumers' needs are increasingly different from the past. The environment is also affected by this revolution, especially because today's production model is utterly different from that in place during Fordism. In light of the foregoing considerations, this volume discusses the great transformation of work, examining three main aspects: demography, the environment, and technology. This approach is based on the assumption that work and its changing landscape can only be understood if one looks at the big picture, i.e. if one adopts a more inclusive approach.

Demography

The emergence of new technologies is not the only factor that will pose challenges to today's and tomorrow's world of work. The demographic changes marking Italy's population will also play a significant role in the years to come. In this regard, an increase has been reported in the average age of the population, in Italy as in other developed countries, which is caused by three concurrent factors (i.e. population ageing, lower number of births and higher life expectancy). The progress made in sciences and medicine, coupled with better living conditions, has caused a significant decrease in mortality rates.

This state of affairs will compel management to deal with older employees, while concurrently facing the continuous technological innovation which requires skills updating, especially digital ones. Technology should not be feared by workers who are not digital natives, far from it. New technologies – e.g. collaborative robotics and augmented reality – might help workers aged 50 and over to carry out tasks requiring physical exertion efficiently.

In addition, the spread of automatized processes – which will increasingly reduce physically demanding tasks – will help reduce workers' health and safety risks resulting from strenuous work.

Chronic diseases will be more challenging to deal with, as the World Health Organisation (WHO) has reported that they will be on the rise in the next decades. Consequently, the number of active workers with chronic conditions will increase. While still fit for work, these workers will have reduced working ability, which might not be compatible with today's fast working pace. Their inclusion and that of other workers with a disability will be a central theme in the years to come.

Demography is also related to the current generational gap. Nowadays, the labour market is marked by a growing dualism between young and senior workers that is gradually setting in. Owing to certain working schemes (e.g. internships) which are devoid of their educational content and are only used to reduce labour costs, new-generation workers have more qualifications than their older peers, yet they face more difficulties at the time of accessing employment.

The Environment

Environmental protection and eco-sustainability have gained high priority on the political and institutional agenda the world over. The effect of climate change, e.g. the increasing number and the seriousness of natural disasters (earthquakes, floods and landslides) has led those concerned to rethink production, distribution and consumption, promoting a transition to a more sustainable economy and implementing tools preventing and managing environmental risks.

In recent years, this process has produced a lively debate about the implications that the shift towards the circular economy might have on the labour market, now and in the future, in terms of jobs and skills. However, there is more. Discussions have encouraged some companies and worker representation bodies to review their strategies on work regulation and human resources management in order to make workplaces more environment-friendly, raising workers' awareness about environmental issues and sustainability-oriented organisational practices.

The circular economy will affect the labour market in relation to employment levels, professional profiles and skills. Making the economy more sustainable will have an effect on existing jobs, and will contribute to refreshing the skills of those already in employment, making them 'greener'.

Education, training and lifelong learning will also play a decisive role, helping the workforce to benefit from the opportunities provided by the circular economy. Of course, industrial relations actors will also have a say, as they can facilitate the process of bringing together labour demand and supply as regards green jobs while ensuring decent employment for both men and women.

In time, the place of production will no longer be relevant, as work will be carried out anywhere. Accordingly, priority will be given to ensuring the safety of both the traditional workplace and that of any place where work is performed. It is against this background that both the employer and the employee are taking steps to protect the environment. Contributions to going beyond the misleading assumption that factors affecting the environment mainly originate at work, thus impacting on workers first, then on nature and the community at large. One reason for this is that the place of work and the surrounding area will not be seen as separate entities, as new technologies will make it increasingly difficult to draw the line between the different spheres of life.

Technology

Technological innovation has always spurred change in production and work settings but has also been a cause of concern for the future of work. In the last ten years, an increasing number of technological tools have been created that were widely used by the public, contributing to cost reduction. By way of example, the price of a personal computer has dropped by 60% in the last 30 years, while that of industrial robots has faced a 25% decrease since 2015 and a further 25% reduction is expected by 2025.

IT tools and industrial robots, which have been employed in manufacturing since the late 1970s, have played a key role in saving workers repetitive and standardised tasks, which were peculiar to Taylorism and mass production. In parallel, business models have focused on customised production in an attempt to establish a closer relationship between producers and consumers. Consequently, technology and new organisational models have changed the role of workers, and intellectual, high-precision ones have increasingly replaced manual tasks. As a result, a significant number of workers who were employed in industrial sectors now operate in the service sector.

Another revolution is taking place today, which will bring about changes triggered by cyber-physical systems, which will help the traditional supply chain to adapt production to consumers' ever-changing needs, laying the foundations for so-called mass customisation. Simply put, on-demand

manufacturing will be possible at reduced costs, so companies operating in this way will carve out big slices of the market for themselves.

Technology will also be used to widen the product base offered to companies, paving the way for so-called 'servitisation' and service industrialisation. This will be possible thanks to service producers who will use processes typical of manufacturing, on the one hand, and items produced in manufacturing which provide additional services, on the other hand.

In this sense, the introduction of the Internet of Things and the Internet of Services in both industrial products and processes can stand the entire manufacturing cycle on its head. Suffice it to think about the sensors used to track items once they have been sold, which are also used to customise them; this is illustrative of the ongoing Fourth Industrial Revolution. The central role of consumers and the opportunity to offer new services calls into question the notion of a service, which is not only related to production management, organisation and distribution but becomes a vital component of manufacturing. The new interpretation given to this concept might lead to establishing new cooperation models between service providers and companies, whereby some tasks are outsourced while insourcing others that were previously considered of little relevance. These technology-led transformations will impact work in essential respects, especially if one considers organisation, skills demand, regulation, the labour market and the industrial relations system.

Book Structure

The book discusses the issues referred to above and consists of three sections. The first one considers demography from two different perspectives. On the one hand, it focuses on chronic diseases and their impact on work, emphasising the role and the regulation of welfare systems. On the other hand, attention is given to youth unemployment and to those forms of employment which might have an impact on young people's employment, e.g. internships. Both these perspectives aim to provide the 'big picture' as regards demographic issues in the new great transformation, by considering all the factors involved.

The second section touches upon the relationship between the environment and industrial relations. The aim here is to assess the validity of the contraposition between 'natural disasters' and 'environmental and technological ones' also in consideration of the ensuing challenges for labour law and industrial relations scholars. Due to the unforeseeable nature of the first group of disasters, welfare systems can only provide emergency

assistance. As for the second category of catastrophes, they are deemed to be preventable, so it is up to legal authorities to establish the cause and effect relationship and to issue sanctions to those held responsible. In this respect, labour law, industrial relations and welfare systems can provide a major contribution in terms of risk prevention and proactive management, especially in relation to ensuring the continuity of the productive system and the protection of people's jobs and income.

The third and larger section of the book broaches the topic of the impact of technology in the context of the Fourth Industrial Revolution – also known as Industry 4.0. Specifically, an analysis is carried out of the challenges that this phenomenon will pose in terms of work regulation, especially when it comes to research, which is still governed by old rules. In the first part of this section, mention is made of Italy's Industry 4.0 plan, where links can be found between technology, work, industrial relations and territory. The book concludes with an investigation of the measures put in place in times of crisis.

CHAPTER ONE

DEMOGRAPHY

THE NEW FRONTIERS OF WELFARE SYSTEMS: THE EMPLOYABILITY, EMPLOYMENT AND PROTECTION OF PEOPLE WITH CHRONIC DISEASES

1. Framing the Issue

A growing share of the economically active population[1] reports suffering from a temporary inability or a reduced ability to work because of the onset and the course of chronic disease; this paper employs the expression "chronic diseases" to refer to irreversible pathological alterations that require special treatment, long-term monitoring, observation, and care. These include cardiovascular and respiratory diseases, musculoskeletal disorders, HIV / AIDS, multiple sclerosis, several types of cancer, diabetes, obesity, epilepsy, depression and other mental disorders.

As far as the cases examined in this paper are concerned[2], the impact that chronic diseases have on sick people in terms of income, job opportunities, career prospects and social inclusion varies considerably, as do the effects on their family members who are tasked with providing care and assistance (i.e. caregivers).

Some measures that might help cope with these specific issues are provided by the national systems of social security (e.g. early retirement programmes ensuring access to pension schemes or sickness allowances) and bylaws and collective bargaining (e.g. the total or partial suspension. of employment and the provision of wage compensation on a temporary basis) (see par. 2).

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[1] Also known as the "labour force", which includes both employed and unemployed people.

[2] For an overall evaluation of the impact that chronic diseases have on post-industrial societies that considers economic indicators and socio-economic aspects, see P. BRAVEMAN, L. GOTTLIEB, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes,* Public Health Reports, 2014, Supplement 2, pp. 20-31 and the bibliography therein. See also, UNITED NATIONS DEVELOPMENT PROGRAMME, *Addressing the Social Determinants of Noncommunicable Diseases,* Discussion Paper, October 2013.

However, little attention has been paid to the economic impact that chronic diseases have on healthcare and welfare systems[3]. Particularly, in the medium and the long run. The rise in life expectancy[4] exacerbates the significant deficiencies of these systems as regards their financial sustainability, the resulting upward adjustment of the retirement age and stricter criteria to access pension benefits[5].

1.1. Chronic Diseases: The Sustainability of Healthcare and Welfare Systems

As is widely known, people's longevity increases the demand for healthcare services and long-term social benefits, bringing about higher public expenditure[6]. Nevertheless, budget constraints and the ensuing tightening of the subjective and objective criteria to access pension and welfare benefits, compel people to postpone retirement and often to cope

[3] This point is made cogently by R. BUSSE, M. BLUMEL, D. SCHELLER-KREINSEN, A. ZENTNER, *Tackling Chronic Disease in Europe: Strategies, Interventions and Challenges,* European Observatory on Health Systems and Policies, World Health Organization 2010, who argue that "there is considerable evidence on the epidemiology of a chronic disease, but little on its economic implications" (p. 19). See also UNITED NATIONS, *World Population Ageing 2013,* Department of Economic and Social Affairs, ST/ESA/SER.A/348, 2013, p. 75.

[4] Cf. D.E. BLOOM, E.T. CAFIERO, E. JANÉ-LLOPIS, S. ABRAHAMS-GESSEL, L.R. BLOOM, S. FATHIMA, A.B. FEIGL, T. GAZIANO, M. MOWAFI, A. PANDYA, K. PRETTNER, L. ROSENBERG, B. SELIGMAN, A.Z. STEIN, C. WEINSTEIN, *The Global Economic Burden of Noncommunicable Diseases,* Geneva, World Economic Forum, 2011. A 10-year increase has been reported in Europe in the last 50 years in relation to life expectancy. EUROPEAN COMMISSION, *Demography Report: Older, more numerous and diverse Europeans*, Commission Staff Working Document, Luxembourg, Publications Office of the European Union, 2011, p. 33.

[5] Cf. OECD, *Pensions at a Glance 2013: Retirement-Income Systems in OECD and G20 Countries*, Paris, 2013 and EUROPEAN COMMISSION, *Pension adequacy in the European Union,* Brussels, 2012. In literature: M. SZCZEPAŃSKI, J.A. TURNER (eds.), *Social Security and Pension Reform: International Perspectives,* Upjohn Institute, Kalamazoo, 2014; A. GRECH, *Assessing the Sustainability of Pension Reforms in Europe,* in *Journal of International and Comparative Social Policy,* 2013, pp. 143-162.

[6] Cf. F. BREYER, F. COSTA-FONT, S. FELDER, *Ageing, Health, and Health Care,* in *Oxford Review of Economic Policy,* 2010, pp. 674-690 and M. SUHRCKE, D.K. FAHEY, M. MCKE, *Economic Aspects of Chronic Disease and Chronic Disease Management,* in E. NOLTE, M. MCKEE (eds.), *Caring for People with Chronic Conditions: A Health System Perspective,* Maidenhead, Open University Press, 2008, pp. 43–63.

with physical, psychological, psychosomatic and psychosocial diseases while still at work (e.g. stress, anxiety, panic, depression, cognitive impairment, fatigue, and muscle weakness). In turn, this hampers the performance of day-to-day working tasks and translates into higher rates of absenteeism[7].

At present, no data or reliable projections are available relating to the overall incidence of chronic diseases on the economically active population[8] and employment trends[9]. One explanation for this is that workers tend to hide their real medical conditions from their employers because of the consequences that disclosing such information might have on their remuneration and career prospects.

However, the European Network for Workplace Healthcare Promotion estimated that almost 25% of the working age population in Europe experience disorders caused by at least one chronic disease[10] and that the share of the chronically ill in employment is equal to 19% of the labour force[11]. On the contrary, the rate of labour market participation in Europe

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[7] Cf. the comparative analysis from EUROFOUND on *Employment Opportunities for People with Chronic Diseases*, European Observatory of Working Life - EurWORK (http://www.eurofound.europa.eu). With reference to Italy, cf. ISTAT *Limitazioni nello svolgimento dell'attività lavorativa delle persone con problemi di salute, op. cit*.

[8] Cf. For each chronic disease, OECD, *Health at a Glance: Europe 2012, OECD* Publishing, 2012, pp. 34-48. Cf. also WORLD HEALTH ORGANIZATION, *Noncommunicable Diseases Country Profiles 2011,* WHO Library Cataloguing-in-Publication Data, 2011 (p. 98 provides data on Italy).

[9] In reference to Italy, see ISTAT, *Limitazioni nello svolgimento dell'attività lavorativa delle persone con problemi di salute,* Report May 2013. A staggering 6.5 million people in the 15 to 64-year-old age group (that is 16.5% of the working population) reported to suffer from one or more chronic diseases that have different impacts on their working life.

[10] Cf. *European Network for Workplace Health Promotion, PH Work Promoting Healthy Work for People with Chronic Illness: 9th Initiative (2011 - 2013)*, 2013. Data are more detailed when it comes to the United States, where 40.3% of those in the 20 to 44-year-old age group suffer from at least one chronic disease, while 16.8% of those in the same age cohort have been diagnosed with two or more long-term conditions. In the 45 to 64-year-old age group, the share of population affected by at least one chronic disease rises to 68%, and those with two or more irreversible conditions are 42.8% of the total population. Cf. G. Anderson, *Responding to the Growing Cost and Prevalence of People With Multiple Chronic Conditions*, 2010, p. 8.

[11] As estimated by the *Recommendations from ENWHP's ninth initiative Promoting Healthy Work for Employees with Chronic Illness – Public Health and Work,* p. 7.

of people over 55 years old – i.e. the share of the economically active population most at risk of losing the ability to work[12] – is projected to rise by 8.3% and by 14.8% in 2020 and 2060, respectively[13].

In the Eurozone, the estimated impact of chronic diseases on workers over 55 years old is even more significant; a 10% and a 16.7% increase have been said to occur by 2020 and by 2060[14].

Undoubtedly, the labour market participation of people with chronic diseases will become necessary in the long run to cope with the reduction in labour supply, a shortage of skilled workforce, and the pressure on the pension system caused by the considerable ageing of the labour force[15]. In countries such as Italy, Japan and Spain this is especially true where the share of those aged over 65 is expected to peak in 2050, constituting one-third of the entire population[16].

Moreover, investing in healthcare and welfare for the economically active population will increasingly become an "economic imperative"[17] to ensure the sustainability of social security systems.

It should also be noted that a decline of industrial work, employment opportunities and professional qualifications are on the rise in some crucial sectors, such as caregiving, which nevertheless faces some significant issues. This is due to cyclical mismatches between labour supply and demand concerning medical staff[18], and a shortage of professionals with

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[12] Cf. K. KNOCHE, R. SOCHERT. K. HOUSTON, *Promoting Healthy Work for Workers with Chronic Illness: A Guide to Good Practice,* European Network for Workplace Health Promotion, 2012, p. 7.

[13] Cf. EUROPEAN COMMISSION, *The 2012 Ageing Report: Economic and Budgetary Projections for the 27 EU Member States (2010- 2060),* European Economy 2|2012, p. 63.

[14] *Ibidem.*

[15] OECD, *Sickness, Disability and Work: Breaking the Barriers – A Synthesis of Findings Across OECD Countries,* Paris, 2010, p. 22.

[16] OECD, *Sickness, Disability and Work: Breaking the Barriers etc., op. cit.*, p. 24.

[17] Cf. HEALTHY WORKING LIVES, *Managing a Healthy Ageing Workforce: A National Business Imperative,* NHS Health Scotland, 2012.

[18] Cf. T. ONO, G. LAFORTUNE, M. SCHOENSTEIN, *Health Workforce Planning in OECD Countries: A Review of 26 Projection Models from 18 Countries,* OECD Health Working Paper, n. 62/2013 and M. SCHOENSTEIN, *Health Labour Market Trends in OECD Countries,* OECD Health Division, Global Health Workforce Alliance Forum Recife, 11 November 2013. For a summary in Italian, cf. A. SANTOPAOLO, F. SILVAGGI, G. VIALE, *La programmazione dei fabbisogni di medici e infermieri nei Paesi OCSE: verso un modello multi-professionale per rispondere alle sfide dell'invecchiamento e delle malattie croniche,* in *Bollettino ADAPT,* n. 31/2014.

the necessary skills to understand[19] and manage the problems experienced by people with chronic diseases (e.g. the desire to return to work, re-employment).

Significantly, the estimated cost to treat chronic diseases in Europe is 700 billion euro that is between 70% and 80% of total healthcare expenditure[20]. A steady increase has also been reported in the share of people requesting sick leave, taking early retirement and living on long-term disability allowances, who account for 10% of the labour force in some countries[21].

An international study conducted by the Harvard School of Public Health (HSPH) for the World Economic Forum[22] estimates that, between 2011 and 2030, there will be a $47-trillion cumulative loss of output due to chronic diseases and mental illnesses connected to healthcare and social security, reduced productivity and absenteeism, prolonged disability and the consequent reduction of income for the families involved.

More precisely, 1.2% of GDP of the OECD area involves disability and related initiatives (2% if sick pay entitlements are factored in), that is some 2.5 times the cost of unemployment benefits[23]. Measured as a percentage of total public social expenditure; the average cost of disability in the OECD area amounts to 10%, with peaks of 25% in some countries.

Not surprisingly, major concerns arise from the projections of healthcare and social security expenditure for the next decades[24]. These concerns are of an economic nature and refer to the steady increase in chronic diseases, which develop at a higher pace than does the ageing of

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[19] In this perspective, Regulation No. 2013/1291/EU of 11 December 1991 provides some useful insights into the *Horizon 2020* framework programme of research and innovation. Cf. annex 1, part III ("Challenges for society"), where explicit reference is made to the emergency caused by chronic diseases and their economic and social costs.

[20] EUROPEAN COMMISSION, *The 2014 EU Summit on Chronic Diseases – Conference Conclusions,* Brussels, 3 - 4 April 2014, p. 1.

[21] Cf. OECD, *Sickness, Disability And Work Keeping On Track In The Economic Downturn,* OECD Background Paper, Paris, 2009, p. 10.

[22] Cf. The study by D.E. BLOOM, E.T. CAFIERO, E. JANÉ-LLOPIS, S. ABRAHAMS-GESSEL, L.R. BLOOM, S. FATHIMA, A.B. FEIGL, T. GAZIANO, M. MOWAFI, A. PANDYA, K. PRETTNER, L. ROSENBERG, B. SELIGMAN, A.Z. STEIN, C. WEINSTEIN, *The Global Economic Burden of Noncommunicable Diseases, op. cit.*, p. 29.

[23] Cf. OECD, *Sickness, Disability And Work Keeping etc., op. cit.*, p. 13. where it is highlighted that in such countries as The Netherlands and Norway, expenditure for disability and sickness benefits accounts for 5% of GDP.

[24] Again, EUROPEAN COMMISSION, *The 2012 Ageing Report: Economic and Budgetary Projections for the 27 EU Member States (2010- 2060), op. cit*.

the population[25]. Some of them, such as obesity, respiratory distress, depression and other mental disorders occur at a young age[26], making it even more difficult to identify and define them, and to devise adequate policy responses.

In the European countries – notably those that adopt the "Bismarck model": Belgium, Estonia, France, Germany, Lithuania, Luxembourg, The Netherlands, Poland, The Czech Republic, Romania, Slovakia, Slovenia, Hungary[27] – where workers and businesses[28] cover the costs of healthcare expenditure (not pensions), an increase has been reported in the old-age dependency ratio. In other words, the share of those who pay social contributions and actively participate in the labour market is gradually decreasing compared to those who qualify for and access social benefits. The European Commission has estimated that the old-age dependency ratio will double in the next few decades, rising from 26% in 2010 to 52% in 2060[29], with a considerable increase in long-term healthcare and welfare expenditure linked to the ageing of the population[30].

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[25] Cf. *Audizione del rappresentante di Farmindustria presso la Camera dei Deputati nella seduta n. 5 di lunedì 29 luglio 2013*, p. 19 (available at www.camera.it).

[26] Cf., among others, J.C. SURIS, P.A. MICHAUD, R. VINER, *The adolescent with a chronic condition. Part I: developmental issues,* in *Archives Disease in Childhood,* 2004, pp. 938–942.

[27] Cf. the report for the Committee of the Regions drafted by Progress Consulting and Living Prospects, *The management of health systems in the EU Member States - The role of local and regional authorities*, European Union, 2012, pp. 98-102. In Italy, the law requiring the national health service to be funded through social contributions paid by employers and employees was repealed by Article 36 of Legislative Decree No. 446 of 15 December 1997. Now the national health service is financed by the government and the regions through the payment of certain levies on productive activities and personal incomes (IRAP and IRPEF). Cf. *Opzioni di Welfare e integrazione delle politiche,* Rapporto CEIS Sanità VIII Edizione, June 2012, p. 96.

[28] A comparative analysis of public expenditure on social protection in Europe (concerning the costs for retirement, disability, unemployment, family, housing, diseases and medical care) is provided by COORDINAMENTO NAZIONALE DELLE ASSOCIAZIONI DEI MALATI CRONICI, *XI° Rapporto nazionale sulle politiche della cronicità,* Rome, pp. 176-180.

[29] EUROPEAN COMMISSION, *The 2012 Ageing Report: Economic and Budgetary Projections etc., op. cit.*, pp. 60-61 and pp. 159-161.

[30] EUROPEAN COMMISSION, *The 2012 Ageing Report: Economic and Budgetary Projections etc.* An overview is provided at pp. 34-36 and pp. 40-41. Cf. also D.E. BLOOM, E.T. CAFIERO, E. JANÉ-LLOPIS, S. ABRAHAMS-GESSEL, L.R. BLOOM, S. FATHIMA, A.B. FEIGL, T. GAZIANO, M. MOWAFI, A. PANDYA, K. PRETTNER, L.

The same holds for those countries where alternative mechanisms are in place to fund the welfare system, especially those such as in Italy with low rates of regular employment. Here, demographic changes and an ageing population place a strain on public expenditure (social security and healthcare) mainly because of the limited implementation of the pay-as-you-go system, which is based on shared financing[31].

1.2. The Impact of Chronic Diseases on Labour Market Dynamics, Productivity and Work Organisation

Besides the concerns related to the initiatives to fund welfare systems, preoccupation also arises as regards another neglected issue[32], namely the impact of chronic diseases on labour market dynamics and, at the micro level, on the organisation of work to manage the presence or the return to work of sick workers. This is because the latter is inevitably less productive and more prone to injuries[33] or severe accidents at work[34], as many studies have pointed out.

ROSENBERG, B. SELIGMAN, A.Z. STEIN, C. WEINSTEIN, *The Global Economic Burden of Noncommunicable Diseases, op. cit*.

[31] On this point, see N. SALERNO, *Le risorse per il welfare del futuro. Insufficienza del pay-as-you-go e disegno multipilastro,* in *Diritto delle Relazioni Industriali,* n. 1/2015.

[32] Of significance is the recommendation of the European Council to assess the impact of this phenomenon and of the national reforms of the health systems on the labour market, productivity and competitiveness, more generally. Cf. COUNCIL OF EUROPEAN UNION, *Council conclusions on the Reflection process on modern, responsive and sustainable health systems*, Employment, Social Policy, Health and Consumer Affairs, Council meeting Brussels, 10 December 2013, p. 4.

[33] According to a recent US study, an overall increase has been reported in the number of occupational injuries among employees with chronic diseases, which were distributed as follows: asthma (+14%), diabetes (+17%), heart diseases (+25%) and depressions (+25%). Cf. K. M. POLLAK, *Chronic Diseases and Individual Risk for Workplace Injury,* in *Occupational and Environmental Medicine,* 2014, pp. 155-166.

[34] In this sense, cf. J. KUBO, B.A. GOLDSTEIN, L.F. CANTLEY, B. TESSIER-SHERMAN, D. GALUSHA, M.D. SLADE, I.M. CHU, M.R., CULLEN, *Contribution of health status and prevalent chronic diseases to individual risk for workplace injury in the manufacturing environment,* in *Occupational and Environmental Medicine,* 2014, pp. 159-166. Cf. also the comparative report written for EUROFOUND, *Employment Opportunities for People with Chronic Diseases, op. cit*., especially the section *Higher exposure to risks and hazards.*

Comparing today's expenditure and population with the projections for 2060, it is labour input that acts as the main lever for growth in Europe. In a context that is characterised by the overall ageing and contraction of the economically active population, also in consideration of the share of people regarded fit for work[35]. Coping with chronic diseases is not only a matter of social inclusion and protection. It also has an impact on the dynamics of labour productivity, with repercussions on the competitiveness of businesses and national economic systems and workers' career paths.

Significantly, chronic diseases are frequently linked to occupational risk factors resulting from working tasks[36], and illnesses developed at work[37] or because of work[38]. These present the case of a "hidden epidemic", as the International Labour Organization[39] has put it, the impact of which is far more significant than that of many acknowledged work accidents, and gives rise to legal disputes, direct and indirect liability and additional costs for employers[40].

As to labour supply and productivity, chronic diseases affect welfare systems, business dynamics and overall employment levels, and result in

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[35] EUROPEAN COMMISSION, *The 2012 Ageing Report: Economic and Budgetary Projections etc., op. cit.*. An overview of the report is available on p 34.

[36] In 2007 the World Health Organization has estimated that there were more than 300,000 fatalities because of various work-related diseases (not including the deaths from injury) the majority of which were chronic diseases. Cf. WORLD HEALTH ORGANIZATION, *Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012−2016,* Copenhagen, 2012, p. 21.

[37] An example is the effects that passive smoking has on the development of tumors and cardiovascular diseases. Cf., among others, I. KAWACHI, G.A. COLDITZ, *Workplace Exposure to Passive Smoking and Risk of Cardiovascular Disease: Summary of Epidemiologic Studies,* in *Environmental Health Perspectives,* 1999, pp. 847-851.

[38] An example of this is the impact of certain psychological and social factors, like work-related stress, job instability, shift work and working long hours. Cf., among others, N.H. ELLER, B. NETTERSTRØM, F. GYNTELBERG, T.S. KRISTENSEN, F. NIELSEN, A. STEPTOE, T. THEORELL, *Work-Related Psychosocial Factors and the Development of Ischemic Heart Disease: A Systematic Review,* in *Cardiology in Review,* 2009, pp. 83-97 and M. KIVIMAKI, J.E. FERRIE, E. BRUNNER, J. HEAD, M.J. SHIPLEY, J. VAHTERA, M.G. MARMOT, *Justice at Work and Reduced Risk of Coronary Heart Disease Among Employees*, in *Archives of Internal Medicine*, 2005, pp. 2245-2251.

[39] ILO*, The Prevention of Occupational Diseases,* Geneva, 2013, p. 4.

[40] An attempt to estimate the cost of occupational diseases is provided by ILO *cit.*, pp. 8-9.

fewer active people and more barriers to labour market entry[41]. As early as in 2007, the International Labour Organization reported that, in Europe, only 66% of the unemployed/jobless people between 16 and 64 years old had an opportunity to find a job; this percentage decreases to 47% for the chronically ill, and 25% for those affected by a severe disability[42].

The "great crisis" that began in 2007 with the collapse of the financial markets inevitably worsened the odds to find employment for people with a chronic disease, particularly for those suffering from mental disorders[43]. Those that fall within this statistic are more willing than before to search for a job, because of the reduction in public spending and the tightening of the criteria regarding retirement age or to qualify for permanent disability allowances.

The estimations from the Organization for Economic Cooperation and Development – which are in line with the data contained in the Report of the European Commission on Disability[44] and the very detailed information provided by the comparative analysis on chronic diseases by EUROFOUND[45]. Reporting that the employment rate of those with chronic diseases is just over half of the economically active population, while the unemployment rate is twice as much[46].

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[41] Cf. R. BUSSE, M. BLUMEL, D. SCHELLER-KREINSEN, A. ZENTNER, *Tackling chronic disease in Europe: Strategies, Interventions and Challenges, op. cit*., pp. 20-24, more specifically the overview, the classification of chronic diseases, and the conclusions referred to in the relevant literature.

[42] Cf. ILO, *Equality at Work: Tackling the Challenges. Global Report Under the Follow-Up to the ILO Declaration on Fundamental Principles and Rights at Work,* Geneva, 2007, pp. 44-45. Cf. also S. GRAMMENOS, *Illness, Disability and Social Inclusion,* European Foundation for the Improvement of Living and Working Conditions, Dublin, 2003, pp. 43-47.

[43] Cf. S. EVANS-LACKO, M. KNAPP, P. MCCRONE, G. THORNICROFT, R. MOJTABAI, *The Mental Health Consequences of the Recession: Economic Hardship and Employment of People with Mental Health Problems in 27 European Countries,* in *PLOS ONE,* 2013, pp. 1-7.

[44] EUROPEAN COMMISSION, *European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe,* COM (2010) 636 def., p. 7.

[45] Cf. the comparative study of EUROFOUND on *Employment opportunities for people with chronic disease, op. cit.* (esp. the section *Employment situation of people with chronic diseases,* the national reports are available at www.eurofound.europa.eu, and the documentation can be accessed at the ADAPT Observatory on Work and Chronic Diseases free of charge at the online platform http://moodle.adaptland.it (heading *Osservatori*).

[46] OECD, *Sickness, Disability and Work etc., op. cit*., p. 23 and p. 31, 32, 37.

This group of people faces objective difficulties at the time of entering and re-entering the labour market which is often associated with psychological strain and uncertainty, that lead them to abandon plans of returning to work. They are also the victim of prejudices and stereotypes related to certain chronic diseases and have to cope with forms of work organisation that penalise them as based on extremely rigid criteria, among others workplace presence, fitness for work and productivity. As far as the most vulnerable groups of the population[47] are concerned, some discriminatory practices arise that at times turn into systematic harassment (e.g. bullying) and unavoidably raise questions of social justice, inclusion and equity[48].

Furthermore, the relevant literature has pointed out that a vicious circle is often created, in that unemployment and unstable working conditions are the direct or indirect cause of chronic diseases and worsening health conditions, especially concerning mental disorders[49]. A US study shows how the involuntary loss of employment among those aged over 50 doubles the risk of a heart attack. Japanese research analyses the impact of unemployment on people's lifestyles, emphasising the increase in the use of substances such as tobacco and alcohol, which are among the leading causes of chronic diseases; other studies point out the impact of unemployment on mental disorders (anxiety, stress, depression, etc.) [50]. On the contrary, many studies report that the direct incidence of unemployment

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[47] Cf. EUROPEAN COMMISSION, *European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe, op. cit*., where special reference is made to the vulnerability of women, young people, migrants and those with a mental disease.

[48] Cf. EUROPEAN COMMISSION, *The 2014 EU Summit on Chronic Diseases – Conference Conclusions,* Brussels, 3 - 4 April 2014, *op. cit.*, p. 4. On this point, see also the comparative study from EUROFOUND on *Employment opportunities for people with chronic disease, op. cit*. (esp. the section *Discrimination and prejudice at work)* and the national reports on the issue.

[49] In addition to the pioneering study of M. JAHODA, P.F. LAZARSFELD, H. ZEISEL, D. PACELLI, *I disoccupati di Marienthal,* in *Studi di Sociologia,* 1987, pp. 229-231, see also the references in A. NICHOLS, J. MITCHELL, S. LINDNER, *Consequences of Long-Term Unemployment,* The Urban Institute, Washington, 2013, pp. 9-10. Cf. D. ATRES, STUCKLER, S. BASU, M. SUHRCKE, M. COUTTS, M. MCKEE, *Effects of the 2008 recession on health: A first look at European data*, in *The Lancet,* 2011, pp. 124–125, and, comparatively, EUROPEAN FOUNDATION FOR THE IMPROVEMENT OF LIVING AND WORKING CONDITIONS, *Access to Healthcare in Times of Crisis,* Dublin, 2014.

[50] Cf. the literature provided in S. VARVA (a cura di), *Lavoro e malattie croniche: una rassegna ragionata della letteratura di riferimento,* cit.

on health and mental conditions is irrelevant in those countries, e.g. Germany[51], where a sound system of social security is in place, with unemployment benefits and adequate re-employment services.

Over the last decades, labour law and welfare systems have experienced significant changes due to new modes of production and work organisation induced by technological innovations and globalisation[52]. As seen in the preceding pages, equally important have been demographic changes, the ageing workforce[53] and the consequent impact of chronic diseases on work organisation and labour productivity. Labour law should give careful consideration to these issues, through an approach that favours personal wellbeing based on a more efficient and inclusive labour market, and promotes the modernisation of the regulatory framework and the underlying industrial relations system.

1.3. Research Objectives

This study sets out to highlight the relevance that the impact of chronic diseases on the employment relationship and the social security system might have on labour law and welfare systems, as well as on their future development. Research of this strand has been investigated only to a limited extent[54]. Yet it might contribute to favouring the shift from a

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[51] H. SCHMITZ, *Why are the unemployed in worse health? The causal effect of unemployment on health*, in *Labour Economics,* 2011, pp. 71-78. An opposite view on the same data is provided in L. ROMEU GORDO, *Effects of short- and long-term unemployment on health satisfaction: evidence from German data,* in *Applied Economics,* 2006, pp. 2335–2350.

[52] Cf., among others, the MCKINSEY REPORT, *The Future of Work in Advanced Economies,* McKinsey & Company, 2012.

[53] Cf. A. CHIVA, J. MANTHORPE, *Older Workers in Europe,* Open University Press, 2009 and the comparative study carried out by EUROFOUND, *Sustainable Work and the Ageing Workforce,* Luxembourg, 2012 and OECD, *Ageing and Employment Policies – Country Studies & Policy Review* available at www.oecd.org. In relation to the effectiveness of Italian social security, cf. N. C. SALERNO, *Finanziare il Welfare,* in *Quaderni Europei sul Nuovo Welfare,* 2014, n. 21, especially § 2, 3 e 4 on demography, employment and productivity.

[54] Among the early studies on this subject, cf. S. GRAMMENOS, *Illness, Disability and Social Inclusion,* cit., especially p. 1, where it was argued that "chronic illness, and especially mental illness, remains very much a hidden issue. Discussion about disability tends to get stuck on the issue of rights, where there is a lackluster consensus, but fails to move into the area of active policy implementation. As a result, the disadvantages for people with disabilities or illness do not really change:

merely passive and emergency income support measures – which at times results in labour market exclusion through so-called "medicalization" (see par. 2) – to more innovative approaches based on preventive measures at the workplace (see par. 4) and initiatives promoting the employability and the return to work of workers with chronic diseases (see par 3).

Carrying out innovative research on the relationship between work and chronic diseases is necessary for the future sustainability of welfare systems, and to effectively prompt the renewal of national industrial relations systems. Owing to technological and demographic changes, IR systems are now called to handle the transformations, either in formal and notional terms, of concepts such as "workplace presence", "work performance", "fulfilment of contractual obligations" (see below, par. 5) and to strike a new balance between productivity and equity, inclusion and social justice.

2. Chronic Diseases: The Shortcomings of the Current Responses provided by Labour Law and Social Security Systems

As pointed out above, the employment prospects of people with chronic diseases are limited and have worsened over the past decades following economic stagnation and the crisis of international financial markets. Undoubtedly, reduced or limited workability affects the competitiveness of people with chronic diseases when searching for employment. In a similar vein, those who do have a job are less likely to keep it at the end of their sick leave.

Comparative analysis shows that protection schemes vary considerably across countries, since they depend to a great extent on the specific regulations on dismissal and other aspects, for instance, one's inability to work, poor performances, and absence from work[55].

It is true, however, that the rigid classifications of chronic diseases according to categories laid down in national welfare and social security

they tend to be marginalised, even stigmatised, and feel isolated from many parts of social and public policy as well as the labour market".

[55] Cf. the comparative analysis by S. FERNÁNDEZ MARTÍNEZ, *Enfermedad crónica y despido del trabajador: una perspectiva comparada*, in *Relaciones Laborales y Derecho del Empleo,* n. 1/2015.

regulations, accentuate so-called medicalisation[56] and contribute to creating structural barriers to employment[57].

In Europe as elsewhere[58], the traditional approach of social security systems draws on medically-driven criteria to determine the allocation of disability allowances that often produce early exit from the labour market of those concerned, even when unnecessary.

This brings about adverse effects on patients' morale and physical recovery. It is frequently the case that the chronically ill look for a job not so much for economic reasons, but because entering the labour market is associated with a return to a normal life[59].

The boundaries between workability and disability are blurred, considering that peoples' reaction to the same disease is different either in physical or emotional terms. Further, the course of a chronic disease is unpredictable because many subjective and objective factors come into play, among others the support provided by family, society, and healthcare facilities, personal income, treatment and recovery programmes.

By contrast, current social protection systems still adopt static and standardised models (one-size-fits-all solutions) that do not make it possible to conduct evaluations targeted on each person that consider one's

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[56] The notion of "medicalisation" was employed for the first time in the 2002 issue of the *British Medical Journal* to refer to a widespread attitude in western societies that emphasizes the need for diagnosis, treatment rather than the promotion of people's well-being and health. Cf. R. MOYNIHAN, R. SMITH, *Too Much Medicine?* in *British Medical Journal,* 2002, pp. 859-860 and S. BROWNLEE, *Why Too Much Medicine Is Making Us Sicker and Poorer,* Bloomsbury Publishing, 2010.

[57] This point is made cogently by A. VICK, E. LIGHTMAN, *Barriers to Employment Among Women with Complex Episodic Disabilities,* in *Journal of Disability Policy Studies*, 2010, pp. 76-77. Cf. also L.C. KOCH, P.D. RUMRILL, L. CONYERS, S. WOHLFORD, *A Narrative Literature Review Regarding Job Retention Strategies for People with Chronic Illnesses,* in *Work,* 2013, p. 126.

[58] Cf. The Canadian case described in A. VICK, E. LIGHTMAN, *Barriers to Employment Among Women with Complex Episodic Disabilities, op. cit.*, p. 77-78.

[59] A vast amount of literature points out the therapeutic impact that employment has on sick people. Cf. among others EUROPEAN NETWORK FOR WORKPLACE HEALTH PROMOTION, *Promoting Healthy Work for Workers with Chronic Illness etc., op. cit*. and J.F. STEINER, T.A. CAVENDER , D.S. MAIN , C.J. BRADLEY, *Assessing the Impact of Cancer on Work Outcomes. What Are the Research Needs?* in *Cancer,* 2004, esp. p. 1710, where it is argued that "work is important to the individual, to his or her family and social network, to the employer, and to society at large". In reference to the role of employment as a lever for social inclusion, see also S. ZAMAGNI, *People Care: dalle malattie critiche alle prassi relazionali aziendali,* in *Atti del convegno della Fondazione Giancarlo Quarta*, Milan, 26 October 2011.

ability to work, occupation and tasks, type of contract and working time, work environment and relationship with colleagues and supervisors. Nor do they take into account elements such as the characteristics of the firm and the welfare schemes implemented, any physical adjustments related to the disease, the invasive nature of the treatment and its effectiveness, the evolution of the disease, and so on[60].

As authoritatively highlighted by the Organization for Economic Cooperation and Development[61], many people with limited ability to work are considered by current welfare systems unfit for work, even when this is not entirely the case. The entitlement to a disability allowance does not require beneficiaries to search for a job actively. In addition, in many countries, it is the law itself that prohibits the recipient of a disability allowance from working. Otherwise, they might lose their disability benefits, which are only slightly above subsistence levels[62].

Ensuring adequate protection to those with a permanent or temporary inability to work does not come down to merely protecting the labour market and the employment relationship. This is an issue to be dealt with from a medical and social perspective, as the question being posed is whether or not patients have to integrate their disability benefits resulting from their inability to work[63].

Compounding the picture are national policies relieving employers from certain formal obligations. While still required to bear the labour costs of their employees, they are released from providing practical solutions to the issues faced by workers with chronic diseases (e.g.

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[60] Cf. T. TASKILA, J. GULLIFORD, S. BEVAN, *Returning to Work Cancer Survivors and the Health and Work Assessment and Advisory Service,* Work Foundation, London, 2013, esp. 3, where it is highlighted that "successful work retention for people with a diagnosis of cancer depends not only on the severity of one's condition but also on the individual's capacity to cope with crises or with fluctuations in health or functional capacity. The coping process nevertheless depends on several social aspects of work, such as the work environment and the amount of support one gets in the workplace. This process is also affected by the extent to which healthcare services prioritise work as a clinical outcome and a welfare system that supports job retention". In the same perspective, cf. J.F. STEINER, T.A. CAVENDER, D.S. MAIN, C.J. BRADLEY, *Assessing the Impact of Cancer on Work Outcomes. What Are the Research Needs?,* in *Cancer*, 2004, pp. 1703-1711.

[61] Cf. OECD, *Sickness, Disability and Work Keeping On Track In The Economic Downturn, op. cit*., here pp. 17-18.

[62] Again OECD, *Sickness, Disability and Work etc., op. cit*., p. 18.

[63] *Ibidem.* For a useful overview of Italian legislation on disability, cf. M. CINELLI, *Diritto della previdenza sociale*, Giappichelli 2013, cap. XI.

absence from work). On their part, workers find it more advantageous to draw disability benefits permanently – and concurrently take up undeclared work – rather than benefitting from temporary unemployment benefits and having their remuneration reduced because of lower productivity or higher rates of absenteeism.

Conceived in an economic, social and demographic scenario that was similar to the current one, the social security systems in place in Western European countries[64] now appear inadequate to attend to the issues resulting from chronic diseases discussed thus far[65] that can be regarded as new if we consider their scope, seriousness and economic impact. Factors such as this and others indirectly contribute to shrinking the employment and re-employment opportunities for people suffering from a chronic disease.

Current labour laws and collective agreements also provide barriers and disincentives to work, particularly in Europe and North America, the traditional principles of non-discrimination and equal treatment[66] undoubtedly ensure a broad and modern set of formal rights and protection[67]. Yet the practical implications of these safeguards are frequently

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[64] As to traditional welfare systems, cf. F. GIROTTI, *Welfare State. Storia, modelli e critica,* Carocci, Rome, 1998.

[65] Cf. also S. ZAMAGNI, *People Care: dalle malattie critiche alle prassi relazionali aziendali, op. cit*., "the welfare state in place in Europe as elsewhere following World War II is based on the idea that if someone is not fit for adequately carrying out certain tasks cannot think of staying on at work".

[66] Cf. S. FERNÁNDEZ MARTÍNEZ already referred to *Enfermedad crónica y despido del trabajador: una perspectiva comparada*, *op. cit.*, spec. § 2. In relation to European anti-discrimination legislation, cf. FREDMAN, *Discrimination Law*, Clarendon Law Series, 2011; E. ELLIS, P. WATSON, *EU Anti-Discrimination Law*, Oxford University Press, 2012; B. DOYLE, C. CASSERLEY, S. CHEETHAM, V. GAY, O. HYAMS, *Equality and Discrimination*, Jordan Publishing Limited, 2010; D. SCHIEK, V. CHEGE (eds.), *European Union Non-Discrimination Law. Comparative Perspectives on Multidimensional Equality Law*, Routledge-Cavendish, 2009. For an overview of North American anti-discrimination EU legislation, cf. P. BURSTEIN, *Discrimination, Jobs and Politics. The Struggle for Equal Employment Opportunity in the United States since New Deal*, The University of Chicago Press, 1998; R. C. POST, R.B. SIEGEL, *Equal protection by Law: Federal Antidiscrimination Legislation after Morrison and Kimel,* in *The Yale Law Journal*, 2000, pp. 441-526. As for the Italian case, cf. A. LASSANDARI, *Le discriminazioni nel lavoro. Nozioni, interessi, tutele*, Wolters Kluwer Italia, 2010.

[67] Cf. the comparative study carried out for EUROFOUND, *Employment opportunities for people with chronic disease, op. cit*. (esp. the section *Main policy measures and initiatives at national level*) and the national reports available at EUROFOUND's website (www.eurofound.europa.eu). The international literature

overlooked, as are the preventive measures at work (see par. 4), the subjective and objective conditions of the chronically ill and the features of the companies they work for (see par. 5).

Consequently, the limited effectiveness of formal labour laws[68] comes as no surprise. In many countries, and along the lines of what happens with welfare systems, chronic diseases are considered through a passive and standardised approach, without ensuring economic incentives to employers, ad-hoc protection and promotion, and above all active policies favouring job retention and the return to work, along with medical and psychological support[69]. If anything, the numerous formal requirements in

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has given empirical evidence of some major developments at a company level when dealing with chronic diseases. This translates into forms of support given to workers, who only in a few cases have been discriminated. Cf. the study on a group of female workers affected by breast tumour conducted by R.R. BOUKNIGHT, C.J. BRADLEY, L. ZHEHUI, *Correlates of Return to Work for Breast Cancer Survivors,* in *Journal of Clinical Oncology,* 2008, pp. 345-353, esp. p. 148 and p. 150, where it is stated that "more than 80% of patients returned to work during the study period, and 87% reported that their employer was accommodating to their cancer illness and treatment" and that "few women (7%) reported problems with discrimination because of cancer, suggesting that this was not a widespread problem for breast cancer patients in our sample".

[68] The low effectiveness of the formal safeguards provided by labour law is highlighted, among others, by F. DE LORENZO, *Presentazione Progetto ProJob: lavorare durante e dopo il cancro* (proceedings) ADAPT – FAVO, 11 September 2014, Rome, available at the ADAPT Observatory on Work & Chronic Disease.

[69] Cf. the work by A. DE BOER, T. TASKILA, S.J. TAMMINGA, M. FRINGS-DRESEN, M. FEUERSTEIN, J.H. VERBEEK, *Interventions to enhance return-to-work for cancer patients,* in *Cochrane Database of Systematic Reviews,* 2011, esp. pp. 3-4. A classification is provided of those interventions to help workers with cancer to return to work, which can be also applied to anyone with a chronic disease. Such measures are: (1) *Psychological* ("any type of psychological intervention such as counselling, education, training in coping skills, cognitive-behavioural interventions, and problem solving therapy, undertaken by any qualified professional (e.g. psychologist, social worker or oncology nurse"); (2) *Vocational* ("any type of intervention focused on employment. Vocational interventions might be person-directed or work-directed. Person-directed vocational interventions are aimed at the patient and incorporate programmes which aim to encourage return-to-work, vocational rehabilitation, or occupational rehabilitation. Work-directed vocational interventions are aimed at the workplace and include workplace adjustments such as modified work hours, modified work tasks, or modified workplace and improved communication with or between managers, colleagues and health professionals"); (3) *Physical* ("any type of physical training such as walking, physical exercises such as arm lifting or training of bodily functions such as vocal training"); (4) *Medical or pharmacological* ("any type of medical intervention e.g.

place to protect workers with a chronic health condition sometimes act as a disincentive to employers to the point that they employ subtle practices that border on discrimination in order not to hire sick workers. They fear that, by concluding an employment relationship with them, they will have to deal with complex procedures concerning their termination for economic reasons, should sick workers fail to integrate with their colleagues at work or because of their inability to work[70].

In considering the return to work of those who lost their job because of an illness, the poor results recorded by specific measures should be seen as equally predictable. These include the low effectiveness[71] of reserved employment (e.g. designating some occupations to sick workers), certain tax exemptions and the possibility to temporarily suspend[72] the employment relationship laid down by many legal systems, that usually applies only to firms with a given number of employees[73].

The few studies on this topic have highlighted that the implementation of the quota system for workers with chronic diseases has produced some results in terms of job retention for those who are already employed, while penalising job-seekers, thus negatively impacting their employment trends[74].

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surgical or medication such as hormone treatment"); (5) *Multidisciplinary* ("a combination of psychological, vocational, physical and / or medical interventions").

[70] This aspect is highlighted by the OECD report, *Sickness, Disability and Work Keeping On Track in The Economic Downturn, op. cit.*, p. 25. For an overview of national legislations that prohibit dismissing workers for economic reasons arising from their inability to perform their task, cf. *International Dismissal Survey,* Laga, Belgium, October 2012. With special reference to Germany, cf. R. SANTAGATA, *I licenziamenti in Germania: i presupposti di legittimità,* in *Diritto delle Relazioni Industriali*, 2013, here esp. pp. 889-892. On the case of the UK, cf. *Dismissals for Long Term Sickness Absence,* in Library of House of Commons, January 2010.

[71] As far as Italy is concerned, cf. MINISTRO DEL LAVORO, *VI Relazione al Parlamento sullo stato di attuazione della legge 12 marzo 1999, n. 68 "Norme per il diritto al lavoro dei disabili" (anni 2010 – 2011),* Rome, pp. 56-75.

[72] Pursuant to Italian legislation (Article 14 of Act No. 68/99), employers in the private sectors and certain public entities that cannot hire the number of disabled workers required by the law can be partly relieved of such obligation upon payment of a contribution to the Regional Fund for the Employment of Disabled People.

[73] For a comparative analysis cf. the study carried out for EUROFOUND on *Employment opportunities for people with chronic diseases,* and the national reports widely referred to in this paper.

[74] Still OECD, *Sickness, Disability and Work Keeping On Track in The Economic Downturn, op. cit*., p. 25.

Even without considering those elusive practices put in place by some employers, hiring and keeping workers with a chronic disease should not be done to fulfil a legal obligation and avoid sanctions. It requires a positive attitude and the active participation of both employers and workers that should be based on mutual adaptation in order to reconcile their respective needs (so-called "sustainable work", see par. 5).

To ensure treatment and care and avoid the dismissal of the chronically ill, suspension from work also plays a part, although applying for limited periods. Further, despite some innovations introduced by collective bargaining (see par. 5), work suspension is not adequate to manage long-term and severe diseases as chronic ones, which also require flexible working hours and working tasks for both workers and their families[75]; this is the only way to reconcile the worker's willingness to participate in the working life actively and the employer's need to be efficient and productive.

Another aspect to consider is that the foregoing suspension and the reduction of the working activity for workers with a chronic health condition come along with lower remuneration – just when they might incur higher expenses (medicines, nursing, assistance and so forth)[76] – and place them at a disadvantage in terms of career prospects and professional growth.

Equally significant is that employers – mainly in Southern Europe, e.g. Italy[77] – express increasing disapproval with granting paid leave and suspension from work to both sick workers and their families. They lament that workers are overprotected and that they repeatedly take time off from work even when not needed. Practice such as this coupled with inadequate monitoring from those in charge, (social security and health authorities)

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[75] Still EUROFOUND, *Employment opportunities for people with chronic diseases, op. cit*., along with the national reports.

[76] Osservatorio sulla condizione assistenziale dei malati oncologici, *6° Rapporto sulla condizione assistenziale dei malati oncologici*, Sanità, Il Sole 24Ore, 2014, p. 28, and *Meeting the needs of people with Chronic Conditions*, National Advisory Committee on Health and Disability, Wellington, New Zealand, 2007, pp. 8-9. Cf. also the data in F. DE LORENZO, *Presentazione Progetto ProJob: lavorare durante e dopo il cancro*, atti del convegno ADAPT – FAVO,11 September 2014, Rome, available at the *ADAPT* Observatory on Work & Chronic Disease.

[77] This risk was pointed out in Italy some ten years ago. *L'assenteismo costa l'1% del PIL,* in *Il Sole 24 Ore*, 5 December 2007. Some similar concerns are regularly raised in the reports from Centro Studi of Confindustria on the labour market and the Italian economy (available at www.confindustria.it).

ends up penalising those who require a long time off from work due to their illness[78].

Consequently, the forms of protection ensured by law and collective agreements based on quota systems, the suspension of the employment relationship and job retention strategies for the time needed for treatment, are designed for salaried and open-ended employment (that in Southern Europe mainly concerns male workers hired by large companies) [79]. Nevertheless, the recent evolution and fragmentation of the labour market reported an intensive use of intermittent, temporary and atypical work, that does not allow those with a chronic disease to benefit from the foregoing safeguards[80] for long periods fully.

Artisans, small business owners, the self-employed and those who are economically dependent on a single principal/client are faced with even more insecurity — falling outside the notion of "legal subordination" and the ensuing safeguards provided by labour law, which are still relevant although salaried employment is no longer the most widespread form of work[81].

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[78]This explains the clamour following the renewal of some collective agreements (e.g. the commerce sector) where the social partners agreed to reduce workers' safeguards in the event of repeated short-term absence from work, in order to focus on the protection of long-term and more serious diseases. Cfr. E. CARMINATI, *Lotta agli assenteisti e maggiori tutele per i malati gravi*, in Bollettino Speciale ADAPT, 7 April 2011, n. 17.

[79] This argument is supported by an examination of female unemployment rates, which are still low in Southern Europe, and the gender of the workforce in atypical and precarious employment. Not to mention that workers are still tasked with caring for family members and sick people. Cf. S. GABRIELE, P. TANDA, F. TEDIOSI, *The Impact of Long-Term Care on Caregivers' Participation in the Labour Market*, ENEPRI Research Report No. 98, November 2011, esp. p. 6; and EUROPEAN COMMISSION, *Long-term Care for the Elderly*, Luxembourg, Publications Office of the European Union, 2012.

[80] Cf., among others, M. GIOVANNONE, M. TIRABOSCHI (a cura di), *Organizzazione del lavoro e nuove forme di impiego. Partecipazione dei lavoratori e buone pratiche in relazione alla salute e sicurezza sul lavoro – Una Literature Review*, 2007 in *Osservatorio ADAPT* Nuovi lavori, nuovi rischi, pp. 9-13. In relation to our analysis, see A. C. BENSADON, P. BARBEZIEUX, F.O. CHAMPS, *Interactions entre santé et travail, Inspection Gènèrale des Affaires Sociales,* Paris, 2013, p. 5.

[81] Cf. among the many contributions in G. DAVIDOV, B. LANGILLE (eds.), *Boundaries and Frontiers of Labour Law,* Hart Publishing, 2006 and, more recently, H. ARTHURS, *Labour Law as the Law of Economic Subordination and Resistance: A Counterfactual?,* Comparative Research in Law & Political Economy. Research Paper, n. 10/2012.